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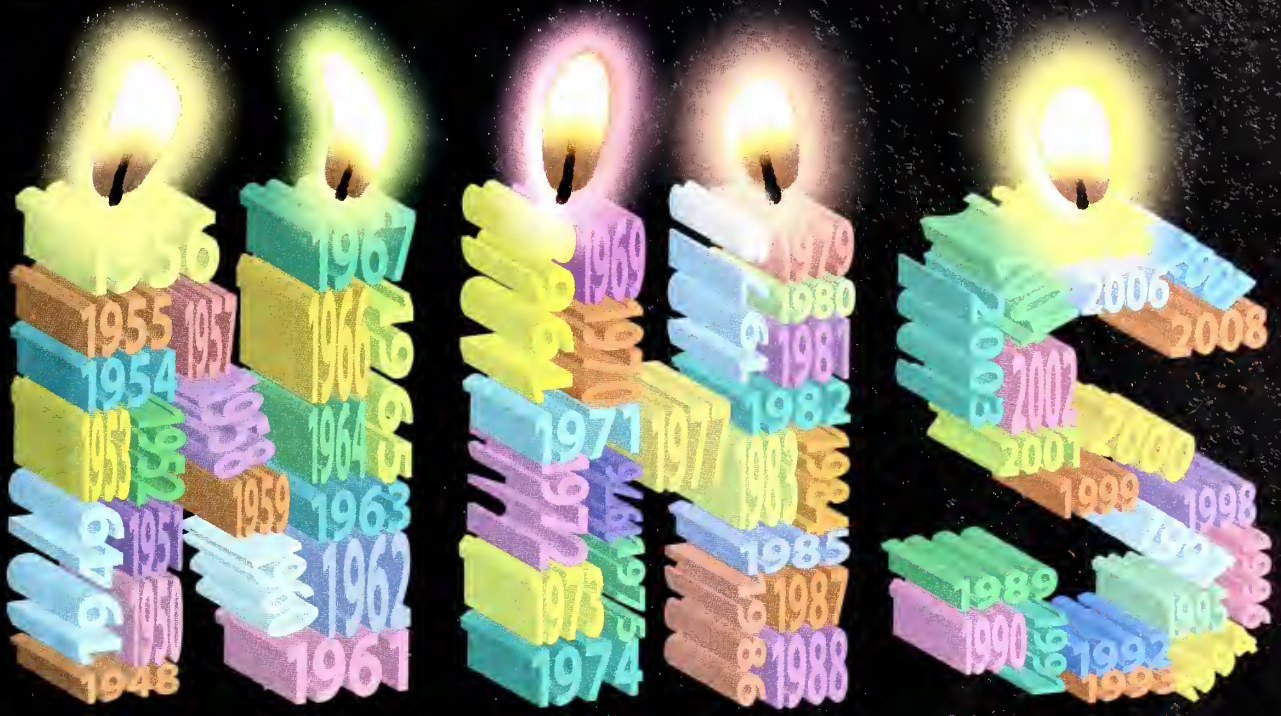

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- Sixty years of health innovation
- Meet the pharmacists practising in 1948
- Xrayser's NHS predictions

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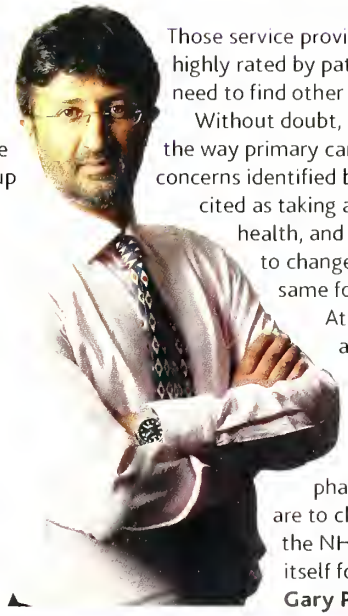
Comment from the Editor

The NHS has been likened to a tanker steadfastly following the direction of travel set at its launch. And as we celebrate its 60th birthday, the core values that guided its launch in 1948 still hold true today: free and equitable access to healthcare from cradle to grave.

But what we need to recognise is that the world around the NHS has changed. Compared to post-war Britain, we are without doubt a healthier, more informed, and more demanding society. We live longer, we expect to have a say in our treatment, and to have access to an array of medical techniques and a formulary of powerful medicines.

Getting the NHS to change its direction of travel is not easy, but the latest raft of policy to come out of the DH has upped the ante. We've already had a blueprint for pharmacy in England, but Darzi Day saw the health minister set out his plan for driving up quality across the whole of the NHS to produce measurable health benefits (page 4). And what makes this latest package of reforms different are the financial levers being applied.

The most interesting at first sight are the introduction of personal health budgets, a constitution of rights for patients, the development of large GP-led health centres that patients can use regardless of where they are registered, and the removal of protected income payments for GPs. As patients travel along care pathways, the plan is that health funding will also.



Those service providers who deliver services that are highly rated by patients will prosper; the rest will need to find other sources of income.

Without doubt, doctors hold the key to changing the way primary care tackles the big public health concerns identified by Darzi. But pharmacists too are cited as taking a "leading role" in preventing ill-health, and if the DH is using reimbursement to change what GPs do, we can expect the same for pharmacy.

At the time of writing, we were still awaiting the publication of the primary and community care strategy that would hopefully provide the detail to Darzi's vision. How this will impact on pharmacy remains unclear, but if we are to change the direction of travel of the NHS, then the profession must brace itself for more reform.

Gary Paragpuri, Editor

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© CMP Medica, Chemist+Druggist incorporating Retail Chemist, Pharmacy Update and Beauty Counter
Published Saturdays by CMP Medica, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE
C+D online at: www.chemistanddruggist.co.uk
Subscriptions: Print and Electronic £240 (UK); £355 (Rest of World); Print only £210 (UK); £325 (ROW); Electronic only £180 (UK); £295 (ROW).
Circulation and subscription: CMP Information Ltd, Tower House, Sovereign Park, Lathkill St, Market Harborough, Leics. LE16 9EF. Telephone 01858 468811 Fax: 01858 434958

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Darzi sets out vision for quality

Pharmacists tasked with publishing account of safety, experiences and outcomes of the services they provide

Max Gosney

Healthcare providers face a tough new set of performance measures under health minister Lord Darzi's plans to ensure quality is integral to the NHS.

Reforms including a quality framework for community services were revealed as part of the health minister's high profile review of the NHS, released on Monday.

Pharmacists will have to publish 'Quality Accounts' from April 2010, detailing safety, experiences and outcomes of services they provide, the review stated.

NHS stakeholders will also be charged with developing their own local performance measures.

Lord Darzi said: "Our goal is that every provider of NHS services should systematically measure, analyse and improve quality."

Practice-based commissioning (PBC) had failed to deliver the improvements in local NHS care

Lord Darzi: PBC has failed to deliver

that the government had intended, the review admitted.

Westminster pledged to "reinvigorate" the scheme. Incentives will ensure PBC extends beyond GPs to involve pharmacists and other clinicians, Lord Darzi said.

Doctors received a further blow with the review announcing the end of protected income payments for practices. No details of the future of pharmacy practice payments were given.

However, all NHS stakeholders could expect patients to have a far greater say over the future direction of NHS cash, the review ruled. The public will be asked to rate NHS services using patient reported outcome measures, Lord Darzi said. And patients suffering from chronic conditions could receive personalised health budgets to give them more control over the services they receive and where they access them from.

Lord Darzi said: "We have to keep up with the expectations of the public. This will mean allowing people to exercise choice and be partners in decisions about their own care."

Lord Darzi echoed the pharmacy white paper's pledge to give the profession a part in a national vascular screening programme to be rolled out in 2009. The government will publicise this through a national campaign.

Darzi at a glance

Quality, quality, quality

- Performance accounts to be published on clinical effectiveness of NHS care
- Incentives in place to reward high quality care
- PBC to be "reinvigorated"
- Coalition for Better Health to tackle obesity

Patient power

- NHS constitution to guarantee patient's rights
- PCTs to prescribe more drugs yet to be approved by Nice
- Long-term condition sufferers to get a personalised care plan
- Personalised healthcare budgets
- Patients to get personalised prospectus of local services

Education

- Independent body set up to advise the DH on education of NHS staff including pharmacists

Review plays to profession's strengths, says industry

Lord Darzi's plans to hand the public more power over the NHS play into the hands of pharmacists, industry representatives have said.

The profession was already focused "first and foremost" on the needs of customers, according to Company Chemists' Association chief executive Rob Darracott.

PSNC said Lord Darzi had made "sensible" and "positive" plans in line with recent government policy on pharmacy.

Sue Sharpe, PSNC chief executive, said: "Like the pharmacy white paper, the next stage review emphasises the importance of providing quality healthcare and choice to empower patients... the government has acknowledged pharmacy is ideally placed to provide this."

The NPA backed the review's commitment to involve pharmacy in a national vascular health screening programme.

However, the organisation called for a government-supported public awareness campaign to support the initiative. NPA chief executive John Turk said: "Patient choice is to be the principle driver for quality improvements...the whole sector will need to think about how pharmacy can be collectively promoted." **MG**

STOP PRESS

The DH was expected to publish on Thursday after C+D went to press how it plans to implement its latest policy in the Primary and Community Care Strategy.

Ronald Davison retired from pharmacy 23 years ago but can still recall the impact of the NHS's introduction in 1948

1948 2008 NHS@60

1948
The birth of the NHS brings healthcare professionals together in one organisation for the first time, to provide services that are free for all at the point of delivery.

1952
A one shilling (5 pence) charge for prescriptions is introduced. Thorazine and Dexedrine are launched by Smith Kline and French.

1953
DNA's structure is unveiled by James Watson and Francis Crick.

Lloyds sets 100-day plan

New chief executive targets improved customer satisfaction by September

Jennifer Richardson

Pharmacies must become as focused on customer service as they are on patient safety, Lloydspharmacy's chief executive has told C+D.

Since taking over from predecessor Justin Ash on May 1, Richard Smith has created a 100-day plan for the multiple business to deliver improved customer satisfaction by mid-September.

Increased customer choice and accessibility through 100-hour contracts and supermarket pharmacies mean that other contractors must focus on service delivery, Mr Smith argued. "We can't afford not to be as good at service provision and speed of service as well as safety."

At Lloydspharmacy, this aim will be delivered through an advanced programme of mystery shopping and corporate communication. Branches reaching a "benchmark" of customer satisfaction by the end of the 100-day plan will be rewarded with leisure vouchers.

Richard Smith: wi... mystery shoppers t... customer service

Mr Smith said he wanted to ensure customers were at the heart of Lloydspharmacy's business.

The blueprint also requires pharmacy teams to take "personal ownership" of branch cost and waste management, in order to "meet the needs of the government in driving down the cost of dispensing", Mr Smith said.

Read more from C+D's exclusive interview with Richard Smith in C+D's July 19 issue

Veteran of 1948 speaks out

NHS 60

They say some things never change. And in pharmacy, at least, that seems to be true.

In the week the NHS turned 60, an 85-year-old pharmacist has recalled how, on July 5, 1948, the most pressing issue for Sunderland pharmacists was the effect a new dispensing GP practice would have on their businesses. "There had been a huge outcry," remembers Donald Davison, who qualified in 1944. "Pharmacists, myself included, thought [the dispensing GP] would end up doing all the dispensing... and chemists would be left out in the rain."

So far, so familiar. But in a C+D straw poll of 25 pharmacists, more than 70 per cent thought pharmacy had improved in the past 60 years. Mr Davison was not so sure. "I'm a bit apprehensive about the way things are going in pharmacy," he said.

Mr Davison was more in agreement with the two thirds of poll respondents who weren't sure the NHS would still exist in another six decades. He said: "That's like saying, will we still have a monarchy? I don't know." Mr Davison rated penicillin the most significant medicine in the NHS' lifetime. **JR**

Locums paid £750 a year, C+D in 1948, pharmacists share memories of 1948: see p12 & 34

News in brief

Society to charge rent

The government must stump up rent if it wants to base the General Pharmaceutical Council (GPhC) at the Royal Pharmaceutical Society's Lambeth headquarters, the RPSGB has stressed. The comment came after the steering group behind the GPhC said it was likely the bodies would co-locate at its latest meeting.

Dawn visit for contractor

Pharmacy minister Dawn Primarolo MP heard how much patients value community pharmacy services when she visited a pharmacy in Bishopsworth, Bristol, last week.

Transcom formed

The Transitional Committee, which is working to produce a prospectus for a new professional body for pharmacy, has now been set up under the chairmanship of Nigel Clarke.
www.chemistanddruggist.co.uk

Glasto pharmacy

Members of the Rock n Roll Pharmacy were still able to help patients on site at Glastonbury this year, despite problems with a wholesale partner meaning the pharmacies could not run as had been planned. Read more at www.chemistanddruggist.co.uk/rocknrollpharmacy

AAH skips Numark

AAH has written to all Numark and Nucare customers offering them business options without the need to be affiliated to the merged Numark symbol group.

MUR ZONE

Four new MUR tips are online now. Find aminosalicylates, mood stabilisers, ulcerative colitis and antispasmodics at www.chemistanddruggist.co.uk/murzone

1954
Smoking is linked to cancer for the first time by the British scientist Sir Richard Doll.

1958
Polio and diphtheria vaccinations programme means that everyone under the age of 15 is vaccinated. Glaxo acquires Allen and Hanburys. Wellcome launches Actifed.

1960
The first kidney transplant takes place. Wellcome launches Contac.

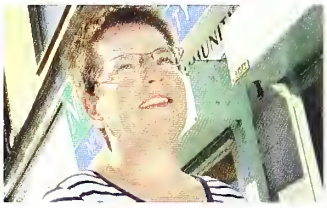
1962
The first full hip replacement is carried out

C+D digital edition More details on p24. Sign up at: www.chemistanddruggist.co.uk/digital

Dispensary TALK

Have you got a business plan for your pharmacy?

"We constantly update it with our regular discussions, but we don't have it written down."
Amanda Jones, Village Pharmacy, Harlington



"Yes – we did it so that we know where we're going. We updated it in 2005 because it gives you a focal point and allows you take stock of what you're doing and if you're going in the right direction."
Cath Boury, Newland Community Pharmacy, Hull

WEB VERDICT:

Yes, I know exactly where I'm going 50%

No, I'm taking things as they come 50%

Armchair view: It's good to know so many pharmacists say they know exactly what they are doing. But does your plan have room for the pharmacy white paper, the Darzi review, and whatever else 2008 has in store?
This week: Will the NHS still exist in another 60 years? Vote at www.chemistanddruggist.co.uk

Cash boost for Scotland

Contract funding tops £165m including £8m boost for public health services

Jennifer Richardson

A 7 per cent global sum boost and an additional £8 million for three new national services should improve contractors' cash flow, the Scottish negotiator has said.

A total of almost £165m in state funding for community pharmacy in Scotland has been agreed between Community Pharmacy Scotland (CPS) and the Scottish Government for this financial year, compared to less than £147m last year.

CPS CEO Harry McQuillan said the committee was "content" with the settlement. He said: "We have been negotiating for an improvement in cash flow for contractors and this should help deliver that."

But Mr McQuillan stressed the 2008-09 funding package was an "interim solution" to category M clawbacks, pending the results of a full cost inquiry due to be carried out in the autumn.

Contractor George Romanes, who runs five pharmacies in the Scottish borders, was "very happy" with the package, which he described as "a step forward". But he added: "Obviously, the big question is what happens after the proper cost inquiry."

CPS and the Scottish Government (SG) last week revealed that national services in smoking cessation, EHC and chlamydia were to be added to the public health service (PHS) element of the contract (C+D, June 28, p7).

George Romanes: "very happy" with deal

Distribution details for an £8m support package for these services were still being discussed, CPS said, but included a reduction in the generics clawback rate from 13.25 to 11.4 per cent.

CPS is also continuing to negotiate over the PHS and minor ailments service. The committee was looking for a "significant uplift" in payments, Mr McQuillan said, and awaiting the SG's response to a proposal made last week.

The SG has committed to raising public awareness of the PHS sexual health and smoking cessation services. A spokesperson said: "We are currently working on the detail but would expect to announce arrangements for publicity shortly."

Walk-in service pilots in Dundee

The first of five Scottish pilots to explore the expansion of community pharmacy walk-in services has been launched in Dundee.

The Albert Street Alliance Pharmacy has extended opening hours and additional services will be added this month. These include a work station to treat mild depression and anxiety, a cardiovascular screening service and nurse-led health checks for weight and blood pressure.

NHS Tayside director of pharmacy Alistair Jack said: "We have received lots of positive feedback from patients."

The year-long pilot is one of five to be set up in line with the Scottish Government's health and wellbeing action plan, published in December.

NHS Lothian was in "detailed discussions" with two Edinburgh pharmacies, a spokesperson said, and NHS Grampian was considering a minor injuries service. The other boards charged with developing pilots are Greater Glasgow & Clyde and Lanarkshire.

The pilots will be evaluated and considered for rollout in other areas. **JR**

Wales to launch national services bid

Wales is looking to follow Scotland's lead in securing more national services for pharmacy.

Community Pharmacy Wales chief executive Paul Gimson said he wants to negotiate services "similar to what is happening in Scotland, looking at the public health role of pharmacists" and linked to services already available, such as smoking cessation and weight management.

He added that such services were looking "a lot more likely" with the ongoing reorganisation of the NHS in Wales. A consultation proposing a reduction in the number of local health boards, which could make negotiations easier, closed last month.

The RPSGB Welsh Pharmacy Board also welcomed the proposals, saying current commissioning arrangements had "caused barriers" to the best use of pharmacists' skills. **ZS**

Which services should get national funding?
zsmeaton@cmpmedica.com

1967 The Abortion Act makes abortion legal for up to 28 weeks of pregnancy.

1970 Glaxo launches the Ventolin inhaler.

1972 CT scans come into use. Beecham launches Amoxil.

1976 SmithKline Corporation launches Tagamet.

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News in brief

NHS should stay free

The public wants the NHS to remain free at the point of use, a YouGov/Fabian Society poll for the 60th birthday of the NHS has found. Respondents also called for maximum waiting times of three months for an operation. www.fabians.org.uk

Warning to PCTs

PCTs planning new GP-led health centres have been told to consider the impact the changes could have on community pharmacy. In a letter to all PCT chief executives, NPA head of external relations Stephen Fishwick warned such centres "could dislocate the existing accessible, community-based network of pharmaceutical care".

Blood test reminder

Pharmacists involved in blood sample collection have been warned by the MHRA not to re-use lancing devices for self-testing by individual patients. These single use devices should be discarded after use.

MPs 'deplore' 100-hours

Regulations will lead to community pharmacy closures, MPs argue

Colin Brown

A cross-party group of MPs has "deplored" the pharmaceutical regulations for allowing supermarkets to offer 100-hour pharmacy services, claiming it will lead to closures of community pharmacies.

Peter Bottomley, the former Tory minister, said: "I think it will lead to closures. The effect is to penalise small pharmacies and I don't think that is right."

Fourteen MPs tabled a Commons motion attacking the changes to the regulations to allow supermarkets "to squeeze small pharmacies out of the market".

The MPs say it is "disgraceful" that the decision-making process vested in PCTs does not allow them to take into account the wishes of customers in determining an application by a supermarket offering 100 hours service.

The group called on the government to change the rules so that the applications can be judged by local PCTs solely on whether they are considered to be "necessary and desirable".

Simon Burns: tabled motion to protect smaller pharmacies

The motion was tabled by Simon Burns, the Conservative MP for West Chelmsford, and highlights the application made by Tesco in Princes Road, Chelmsford, saying it would have an adverse impact on the smaller pharmacies locally in Gloucester Avenue, Wood Street, Writtle Road and Moulsham Street.

100-hour u-turn

A possible 100-hour pharmacy previously highlighted in Parliament by Simon Burns MP is not going to open.

The MP had taken up the case of his constituent Maurice Waldman, whose pharmacy in Chelmer Village near Chelmsford, was threatened by a possible 100-hour Asda opening. Mr Burns visited the pharmacy as part of C+D's Building Bridges campaign.

John Evans, superintendent pharmacist at Asda, told C+D this week that the company was not going ahead with the pharmacy as there was not enough space in the store. He said it had not been a "battle" between him and the independent pharmacy, "we just want the best for our customers".

But Mr Burns said it was "brilliant" news the pharmacy was not going to open. **ZS**

Firefighters rush to the aid of pharmacy staff at Lloydspharmacy in Morayshire, Scotland, after a phosphorus spillage in the store. Two employees at the Forres pharmacy were treated for nausea as a jar, containing the highly flammable substance, was spilt, causing it to give off smoke. Emergency services entered the store wearing breathing apparatus in order to remove the chemical

Supermarket giant faces exemption fight

Tesco's plan to open 100-hour pharmacies is meeting with localised opposition.

In Evesham, Worcestershire, the local commerce and tourism body has written to Wychavon Council, on behalf of six local pharmacies, to object to Tesco's plans.

David Badham, pharmacist at the Stewart Pharmacy, Evesham, said the 100-hour opening was detrimental to patients. He added: "These out of town stores are sucking places dry."

Tesco confirmed it had plans for "a number of these pharmacies". The supermarket firm said its commitment to "good service, convenience and availability" ensured popularity with patients.

But in King's Worthy, Hampshire, customers of a local pharmacy have been signing up to object to a Tesco 100-hour application.

Eric Norgbey of Springvale Pharmacy, said: "We believe [Tesco's application] is likely to undermine the pharmacy... the government needs to have a second look at this."

A Tesco spokesperson responded: "The retail sector is very competitive, but there are plenty of examples where independent shops can exist successfully side by side with larger retailers." Tesco said it had no specific plans for numbers and locations of 100-hour pharmacy applications. **RF**

1978
The world's first test-tube baby, Louise Brown, is born as a result of IVF

1979
The first successful bone marrow transplant on a child is carried out at Great Ormond Street Hospital.

1980
MRI (magnetic resonance imaging) scans are introduced. Keyhole surgery is used successfully for the first time to remove a gall bladder.

1981
Glaxo launches Zantac, Beecham launches Augmentin, Wellcome launches Zovirax and Astra launches Pulmicourt.

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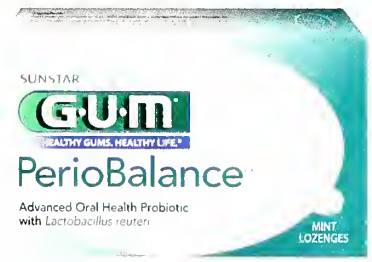

1. Çaglar E et al. Oral Disease 2005, 11 131-137

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Trying to be of service

As Scotland secures yet more national service funding, **Zoe Smeaton** asks why England can't seem to follow its neighbour's lead

Pharmacists in England looked enviously to their neighbours last week, with the news that Scotland had secured funding for national smoking cessation, emergency hormonal contraception and chlamydia advice and treatment services.

These are all services the profession is willing and able to provide in England, so why can't we bag that national funding pot?

As John D'Arcy, interim managing director of Numark, says, there's sufficient evidence and obviousness that pharmacy has a public health role, so "why don't we just get on with it and get more… it is frustrating".

Some industry leaders cite scale as the prohibitive factor. David Currie, CEO of AlbaPharm, says in Scotland "there are fewer organisations and everybody knows everybody else. All the key players know each other so it's easier to get business done".

Others point to key differences in politics between the two nations. While, in England, healthcare is commissioned to meet local needs, Harry McQuillan, chief executive of Community Pharmacy Scotland, explains that for health in Scotland, consistency across the nation is key. "We have poor health statistics within Europe… something that can be developed and offered on a national basis should have a bigger impact on those statistics than small local services," he says.

Clearly the emphasis on local services and commissioning poses challenges to securing national services in England, and some in the profession believe this local focus has gone too far. Ajit Malhi, head of marketing services at AAH, which has just secured a flu vaccination service to be offered under a private patient group direction, explains: "There is a case for making sure you meet different local needs, but things like smoking cessation, sexual health advice or obesity management would be needed by 75 per cent of PCTs … so you might as well have it through a national contract."

But while there is frustration with the system, it is unlikely to change soon, so the profession must look for ways to get around it. One solution could be the directed enhanced services promised in the recent white paper. Under these, the government would direct PCTs to commission certain services from pharmacy.

> "Why can't we bag that national funding pot?"

Alastair Buxton, head of NHS services at PSNC, is optimistic: "We have got one option around directed enhanced services and our discussions on that with the DH will be an opportunity… to get services commissioned across the country."

Mr Currie agrees that directing PCTs to commission enhanced services could help, but warned the government would need to make sure "the directions are followed right down the chain to patients". And Mr Malhi adds there is a danger that if under-resourced PCTs are forced to spend the money on these services, other healthcare services, possibly even pharmacy-related, could suffer.

So the jury appears to be out on whether directed enhanced services can be a catalyst for pharmacy services. But in the meantime it is clear more work must be done to convince the DH of the benefits of national services.

Local innovative services being provided all across England, giving evidence of positive health outcomes at least on a small scale, could be the key. But for them to succeed, more collaboration will be needed. Mr Malhi says while local schemes are a step in the right direction, they are currently "too fragmented" to be used to lobby the government successfully. He said someone needs to "look at those different local projects together, analyse them and put everything to the government in one voice".

Mr McQuillan advises the trick to making such local services useful is to extend them as quickly as possible when some success is shown, rather than waiting too long to roll them out. "When you have evidence it has some success, you should start rolling it out. If someone gets 70 per cent in their degree it's first class, but very often in pharmacy if something isn't 95 per cent it's [seen as] not worth doing." Extending the schemes more quickly could provide more of that much needed evidence for the DH.

With so many projects going on in England, if the profession can work together to use them to convince the government, there might just be a chance it can bag those much coveted national contracts. The future is bright, as Mr Malhi says: "We're still better off than we were a decade ago." With the promise of a national minor ailments scheme and directed enhanced services within the recent white paper, it really is all to play for.

What did the new NHS mean for pharmacy? PostScript takes a trip down memory lane on p34

1982
Astra launches Rhinocort.

1983
The Griffiths Report on NHS management is published. This leads to the introduction of general management in the NHS. Ibuprofen, terfenadine and loperamide switch from POM to P.

1984
Astra launches EMLA cream.

1987
The world's first heart, lung and liver transplant carried out by Profs Sir Roy Calne and John Wallwork at Papworth Hospital in Cambridge. Wellcome launches Aids drug Retrovir.

NiQuitin 21, 14, 7mg Transdermal Patches, NiQuitin Clear 21, 14, 7mg (nicotine). Opaque or transparent transdermal patches 21mg, 14mg, 7mg nicotine (Steps 1, 2, 3) for relief of nicotine withdrawal symptoms during smoking cessation. **Dosage: Adults (18 and over):** *≥10 cigarettes/day;* Step 1 for 6 weeks, then Step 2 for 2 weeks, then Step 3 for 2 weeks. *<10 cigarettes/day;* Step 2 for 6 weeks then Step 3 for 2 weeks. Apply to fresh site (clean, dry skin) once daily. Professional advice if use beyond 9 months. **Adolescents (12-17 years):** As for adults but to seek professional advice if more than 12 weeks treatment required. **Contraindications/Precautions:** Hypersensitivity, cardiovascular disease, severe renal/hepatic impairment, hyperthyroidism, diabetes, phaeochromocytoma, dermatitis. **Side effects:** Local rash, itching, burning, tingling, numbness, swelling, pain, urticaria, heaviness. Depression, irritability, anxiety, nervousness, restlessness, mood lability, drowsiness, impaired concentration, insomnia, sleep disturbance. Allergic reactions, abnormal dreams, nausea, vomiting, dry mouth, GI disturbance, headache, dizziness, palpitations, tachycardia, tremor, dyspnoea, pharyngitis, cough, arthralgia, myalgia, sweating, chest pain, fatigue, malaise, flu-like symptoms. See SPC for full details. **Pregnancy/lactation:** For those unable to quit unaided the risk of continued smoking is greater than the risk of using NRT. Start treatment as early as possible in pregnancy for 2-3 months. Lozenge/gum preferable to patches unless nauseous. Remove patches at bedtime. GSL **PL** 00079/0366, 0367, 0368, 0356, 0355 & 0354. **PL holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Pack size and RSP:** All strengths 7 patches £15.63; Step 1 only 14 patches £29.44. **Date of revision:** July 2007.
NiQuitin and **Click2Quit** are registered trade marks of the GlaxoSmithKline group of companies.

Ask your Pharmacist first

1988

Free breast screening is introduced to reduce breast cancer deaths in women over 50. Zeneca launches Zestril, Astra launched Losec.

1990

The NHS Community Care Act introduces budgets for health organisations, creating the concept of an 'NHS trust'. Wellcome launches Lamictal, Glaxo launches Flixotide and Serevent, Pfizer launches Diflucan.

1991

The first 57 NHS trusts are established. Nicotine gum switches from POM to P. Clotrimazole is available OTC for vaginal thrush. Glaxo launches Imigran for migraine, SmithKline Beecham launches Seroxat.

1992

Pfizer launches Lustral, Istin and Zithromax.

Sixty years of change

NHS 60

From £1 a week wages to rice paper cachets, **Edgar Bryant** recalls life as a pharmacist at the time of the NHS launch

Pharmacy has changed a lot since 1948. At the birth of the NHS, the war was fresh in the collective mind and post-war Britain was still dealing with rationing. Fast-forward 60 years and has the picture changed much? The national average wage may have gone up, but now we're dealing with health inequalities, an ever-increasing gap between the haves and the have-nots and the NHS is creaking from the consequences of a sedentary lifestyle and a more varied (and fatty) diet.

Life in a pharmacy in 1948 was very different to how it is now. Edgar Bryant, a pharmacist originally from Yeovil, registered with the Pharmaceutical Society, as it was then, in the year the NHS was created. He speaks of rows and rows of bottles, locum wages of £750 a year and apprenticeships to become a pharmacist.

Back in 1948 there were two types of pharmacist – the MPS (Member of the Pharmaceutical Society) and the BPharm. As a child, Mr Bryant became fascinated with the pharmacy environment after making trips for his grandfather's liquid medication for chronic bronchitis – there were no antibiotics at this time. Instead of staying at school to do A-levels, Mr Bryant joined a local pharmacy – Timothy Whites and Taylors – at the age of 16 to do his apprenticeship for four years. Mr Bryant remembers how the pharmacy was a notoriously bad payer – 5s a week in his first year, rising by 5s a week each year until his fourth year, reaching the princely sum of £1 a week! However, it did have its advantages – Mr Bryant registered as a prospective candidate for His Majesty in 1941, but pharmacists were one of the exempted professions from military service.

After working for four years, Mr Bryant was keen to do a pharmacy degree and was accepted onto the degree course at Nottingham – then a university college – and attended from 1945-48. While he was there he won the Nottingham studentship in pharmacy.

However, on leaving, Mr Bryant was called up to do National Service for 18 months. Yet, even then he was able to use his pharmacy skills as he was posted to the hospital at RAF Wroughton. Based in the dispensary, he was involved in the Medical Research Council's clinical trials on streptomycin and para-amino salicylic acid (PAS).

The problem with PAS, says Mr Bryant, was the bitter taste. TB patients weren't taking their medication because they couldn't stand the bitterness. First, Mr Bryant tried flavourings such as peppermint and liquorice. Then he worked on 'cachets' – rice paper containing PAS – which when taken by the patients, stopped the bitterness from coming through. This was a success and streptomycin and PAS became the treatment of choice for TB in the 1940s and 1950s. When Mr Bryant finished his National Service the Korean war was just starting and he felt he had had a 'lucky escape'.

Instead, he started working as a locum in pharmacies in Worcester and Nuneaton for a number of months before joining Glaxo as a medical rep in Dorset, Somerset and part of Hampshire. However, after six years of travelling the country he decided to settle down with his family; at this point Mr Bryant and his wife Hazel had two of the five sons they were to have.

This prompted a move back to the south-west, where Mr Bryant bought his pharmacy – A E Bryant – in Poole in December 1959. So how is pharmacy different now to back then? The public respects us more now than in those days, he says. And the same goes for other professions such as doctors and opticians, he adds. A lot of money has been spent on the appearance of the pharmacy since then – it had three refits before he handed it over to his son in 1988. It was also one of the first pharmacies to have a computer, he says, "long before Boots got round to it".

Yet, some things haven't changed: "I don't think pharmacy has got to the stage where it can do away with counter lines [beauty products]", he says. And owning your own pharmacy was often the way to make money, as Mr Bryant remembers only a few bankruptcies in his time.

But some things have changed – when Mr Bryant started with Glaxo, the company was concerned with corticosteroids, penicillin and streptomycin. Then the American firms came in with teromycin and similar products. This confused the general public, who had been used to getting bottles of medicine and were now being dispensed solid doses.

Meanwhile, Mr Bryant says the increase in bureaucracy is one of the reasons he wouldn't want to be a pharmacist today. He says pharmacy in 2008 is "precarious" – with a "tremendous" large number of outlets representing a small number of businesses. He believes this is "not very good for pharmacy and not very good for the public". And pharmacy, he believes, "needs a few strong people" at the moment, "in mind if not in body".

He feels the NHS has been both positive and negative for pharmacy: "They talk about using the pharmacist more and more and the public certainly do take up that challenge, but... it's a very fine balance. They are always saying go and see your pharmacist, but there is no pay on the end of it. We're just nice people!"

See C+D's video interview with Edgar Bryant
www.chemistanddruggist.co.uk/NHS60

1994
Beclometasone nasal spray switches to P, as do cimetidine and famotidine.

1998
NHS Direct launches. Domperidone for nausea becomes a P medicine, as does mebeverine for IBS. Pfizer launches Viagra.

2000
NHS walk-in centres are introduced to offer easy access to a range of services

2001
The morning-after pill, Levonelle, launches over the counter

NHS 60

With the birth of the NHS imminent, the pressure was on to agree a national pharmacy contract in 1948. Steve Ainsworth uncovers a tale of prescription pricing confusion and backtracking

Labour health minister Nye Bevan studies NHS posters prior to its launch

Photo: Getty Images

For politicians, July 5, 1948 was 'Joy Day'. And 60 years on, as the NHS celebrates its Diamond Jubilee, that is how it is remembered. For pharmacists, however, that day six decades ago was not a cause for any great joy. Nor, more surprisingly, was it a day recognised by most people as being particularly joyful either.

National health insurance had already been providing pharmaceutical services for a portion of the employed population since 1911. But now many more millions would be covered. Naturally, pharmacists were asking themselves how many prescriptions they would be called upon to dispense. Would they receive a reasonable fee for the work, or would retail trade in pharmacies have to continue to subsidise health service dispensing?

On June 22, 1948, representatives of pharmacists had paid a visit to Whitehall to tell health minister Nye Bevan that pharmacy contractors in England and Wales would participate in the new service on the agreed terms. It was estimated that the average cost of a prescription would be 2s 5.3d. The annual cost to the NHS was expected to be in the region of £17.5 million.

The pharmacists and the minister of health assumed that around 140 million free prescriptions would be dispensed annually in England and Wales.

Until 1948, however, most doctors had done some dispensing themselves, and no figures on the volume of that activity were available. In the absence of hard data, no accurate assessment could be made of the number of prescriptions that would come to pharmacies when most doctors ceased dispensing.

It did not take long to discover that the estimate of 140 million prescriptions was going to be very wide of the mark. In the first year of the NHS, 202 million

2002
Fluticasone nasal spray for hayfever switches to P status

2004
'Patient choice' pilots trial begins. The UK has a world first with the switch of simvastatin from POM to P – the first OTC medicine for a chronic condition.

2005
The long-awaited switch of chloramphenicol eye drops.

2007
Introduction of the robotic arm leads to groundbreaking heart operations. National smoking ban introduced.

prescriptions were dispensed: the totals for the next few years would fluctuate between 215 and 229 million.

For pharmacists this was good and bad news. The good news was that they were going to get paid much more than expected. The bad news was that the payment system crashed under the weight of work.

Under the pre-1948 National Health Insurance Scheme, 65 to 70 million prescriptions were each priced in full by the staff of the Joint Pricing Committees in England and Wales. Those same staff were now dealing with double the volume of work while trying to recruit and train additional pricing clerks.

Because of staff shortages, pharmacy contractors agreed to accept pricing by averaging "as a temporary expedient and for a limited period". Despite that 'temporary expedient', in the first 12 months prescriptions still piled up at the Pricing Bureaux faster than they could be dealt with, resulting in serious delays in paying pharmacists.

Reacting to a deluge of complaints from pharmacists, the Ministry of Health eventually agreed to make payments on account, final adjustments being made when the prescriptions were finally priced – sometimes as much as 11 months late.

But though pharmacists may have been pleased to be getting payments on account, they had less to celebrate elsewhere. The bills for the NHS were now coming in and the Treasury was less than happy. Cuts would have to be made and pharmacists were a soft target.

As of September 1949, the container allowance was cut by 50 per cent – it would not rise again until November 1955, when it would increase by just one-twentieth of a penny. Nor would that early cut in the container allowance be the end of government parsimony. In May 1950 the on-cost was cut from 33 per cent to 16 per cent.

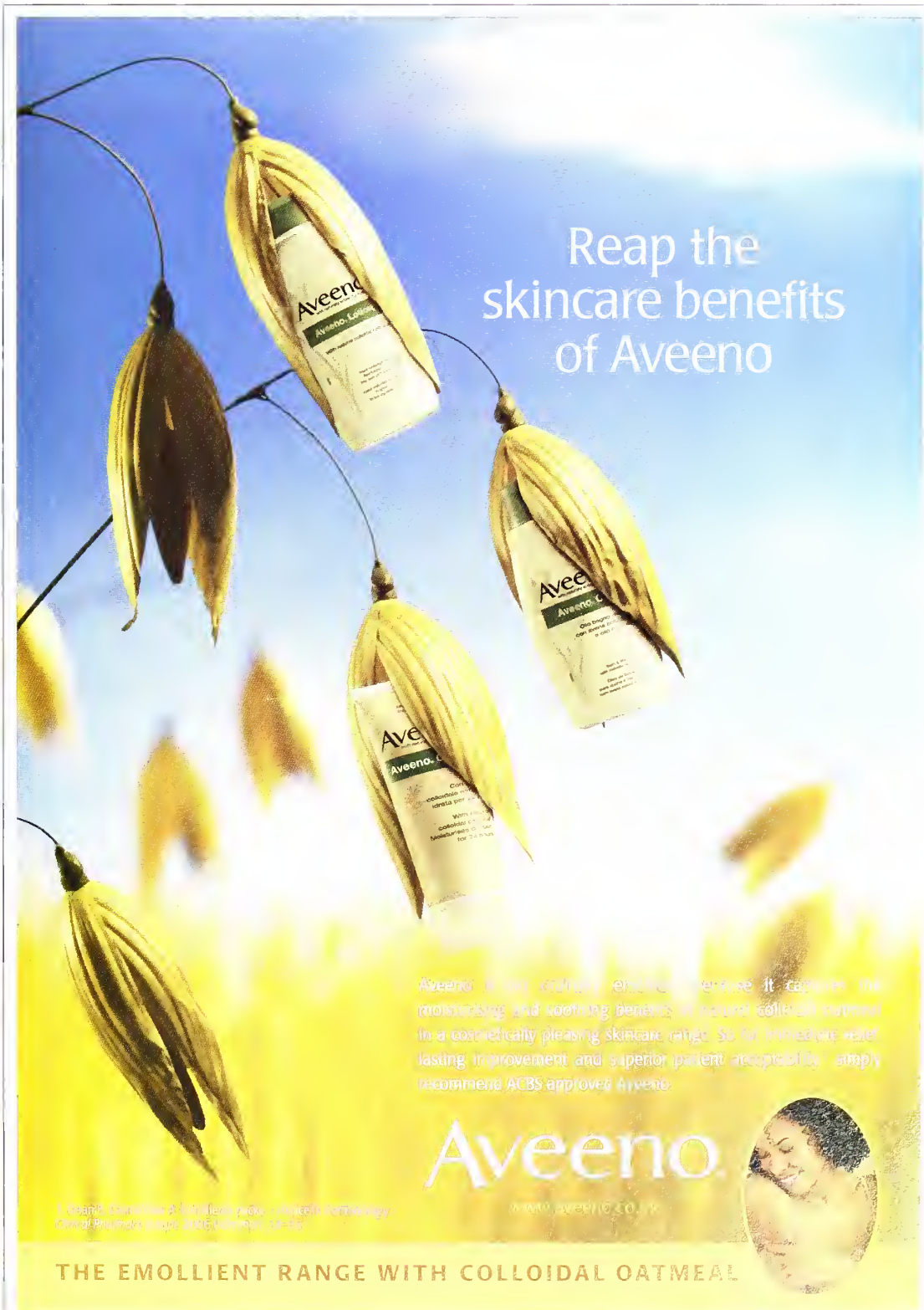
And now the government came under enormous pressure to begin repaying the massive war loans Britain owed to the US. Free teeth, free glasses and of course free prescriptions would have to go.

In June 1952 the one shilling (5p) per form prescription charge was introduced. The number of prescriptions presented for dispensing fell sharply. Would numbers ever recover?

Some saw it as the beginning of the end of NHS dispensing. How wrong they were!

2008

Lord Darzi publishes his final report into the future of the NHS: *Our NHS, our future* sets out a future vision for a new world-class NHS.



Happy birthday, dear NHS: where to next?

The NHS has matured into a truly amazing institution at the age of 60 and one that I hope to be involved with for many years to come.

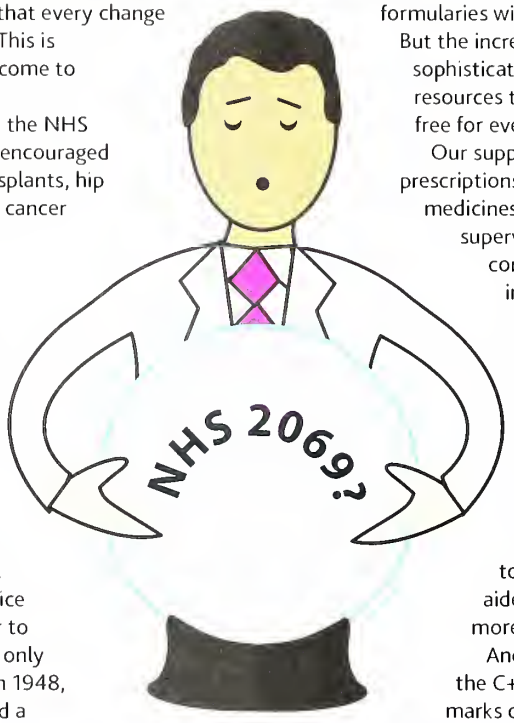
OK, so it has its problems, but so do all large organisations. It's a measure of the importance we place on the NHS that every change or hiccup is pored over and analysed so carefully. This is something truly precious and we don't want it to come to any harm.

People live 10 years longer than they did before the NHS was created. Over the past 60 years the NHS has encouraged such massive steps forward as the first organ transplants, hip replacements and huge advances in treatment for cancer and HIV.

The scale of the organisation in terms of employees is matched only by the Chinese people's liberation army, the Indian railways and the Wal-Mart supermarket chain. I'm confident that I'm working for the best of these four large employers.

Age is relative, so that the NHS could be considered a youngster with its best years still ahead. It is sobering to think that Jesse Boot first took over his father's herbalist shop 71 years before the inception of the NHS. And the pharmaceutical society was already 100 years old.

Even though some elements of pharmacy practice in 1948 hold a quaint attraction, it must be better to be a pharmacist today. An expert dispenser might only have had to deal with four prescriptions an hour in 1948, but he wouldn't have been carrying out MURs, had a large array of safe, effective OTC medicines at his disposal, or been an integral part of public health policy.



I predict that, in another 60 years' time, genetic modification techniques, healthier lifestyles and tightly controlled formularies will have reduced the demand for drugs.

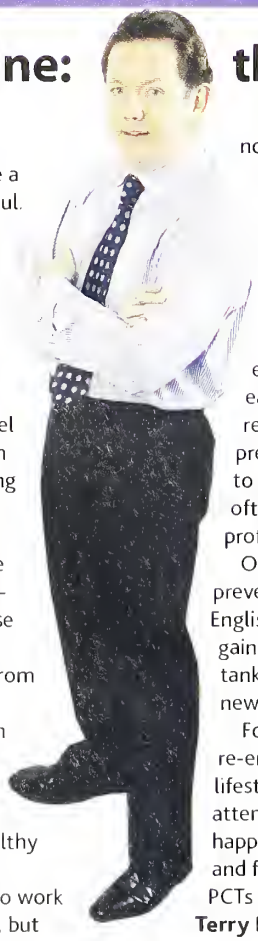
But the increasing elderly population and more sophisticated technologies will put such a demand on resources that the NHS will no longer be completely free for everyone.

Our supply role will have disappeared, with electronic prescriptions sent directly to wholesale depots and medicines delivered either directly to patients or to supervised collection points. Services will be contracted to individuals or organisations independently of a pharmacy premises. There will be far fewer pharmacists, but those remaining will have become highly specialised, mobile service providers.

GP practices will disappear to be replaced by large multidisciplinary polyclinics. Travel infrastructure and IT networks will have improved to such an extent that access to services is less of an issue. Patients will be far more empowered to make their own diagnoses, with computer aided decision making, and able to purchase more of their own treatments.

And if you are still around, please look back in the C+D archives in 60 years' time and give me marks out of 10 for my predictions. That's if you haven't forgotten all about Xrayser by then.

More health, less medicine: the NHS at 60



The current focus on the 60th anniversary of the introduction of our NHS is a good thing. Anniversaries are a time for celebration and reflection; things good for the soul. I am a staunch and loyal supporter of our NHS and for this reason I shun private medical schemes. I firmly believe that my life, the life of my family and that of my community is, and has been, better for the NHS's existence, yet I remain a stern critic of some aspects of our largest civil institution.

At a time when we must congratulate the organisation and those who make it function, which of course I do, I feel society must also continue to debate what is needed from our NHS over the next 60 years and I know that expressing concern and pointing out faults might seem gratuitous at this happy time.

Over the past 60 years we have seen a 10-year increase in life expectancy. Many claim this results from the NHS – free medical care at the point of access – but this of course is naive. The NHS came into being at a time when deaths from infectious diseases were on the decline and deaths from non-communicable diseases were on the ascent. While perhaps five of this 10-year increase in life expectancy can be linked to doctors and medicines, the remaining five years are due to the non-medical determinants of health. Health is good in the UK; we can now boast a life expectancy and infant mortality rate similar to other wealthy nations but also Cuba.

The NHS could learn a lot from Cuba. Our NHS tends to work in isolation from the non-medical determinants of health, but not so in Cuba. Yes, Cuba has a higher number of GPs in primary care but they work on and can influence non-medical determinants of health locally since they have responsibility for community health rather than just individual patients. This framework has a considerable impact on these health determinants and perhaps best explains why a poor country like Cuba can have such good outcomes in health.

Our NHS talks a lot about 'upstreaming', meaning a greater emphasis on preventative medicine, both primary and secondary, eating more healthily, taking more exercise, stopping smoking, reducing the impact of drugs and alcohol, and reducing teenage pregnancies. But many government policies outside health continue to act against this NHS policy direction. In addition NHS decisions too often are made by those with a vested interest, particularly the medical profession, so we end up doing more of what we have always done.

Only a tiny percentage of total NHS spend goes on disease prevention and this must change. If not we are likely to see, as the English CMO has already stated, a considerable amount of the health gains of the last 60 years squandered. The NHS is often seen as a super-tanker; it takes a long time and a lot of energy to turn around when its new destination is identified.

For pharmacy this means becoming a social capital centre, re-engineering our services and being commissioned to support healthy lifestyles and disease management plans. Yes, this is what the NHS is attempting to do with the new pharmacy contracts. But very little is happening, the tanker turns imperceptibly. Enhanced services are few and far between, too few national specifications exist and where they do PCTs are reluctant to commission. Happy Birthday NHS.

Terry Maguire is a community pharmacist in Northern Ireland

C+D Clinical

Anxiety disorders

The final article in this series on psychiatric medicines explains at what stage anxiety is considered a disease and the methods used to treat it

Key points

- Anxiety is not necessarily a sign of mental ill-health, but if it restricts normal activities then further help may be necessary.
- Generalised anxiety disorder features persistent anxiety with autonomic symptoms.
- Panic disorder features discrete episodes of increasing anxiety.
- Treatment often uses both drug and non-drug approaches such as cognitive behavioural therapy.
- Benzodiazepines should be used only for short periods of severe anxiety.
- Antidepressants are effective, even without underlying depressive symptoms.
- Pharmacists can ensure appropriate use of medication, signpost patients to counselling services and advise on the best use of medication.

Stuart Gill-Banham MRPharmS

Marie is a worrier. For as long as she can remember she has worried about things. She worries about how much she worries and she worries when she hasn't got anything to worry about. When her husband or children are out she insists on them calling her regularly so she knows they are safe. Her family are growing weary of this but their irritation only makes her worry more.

It is not uncommon to feel anxious or worried at times. After all, anxiety or fear represents an evolved safety mechanism that protects us from harm. But some people's anxiety goes beyond a useful protection mechanism and starts to impose on how they lead their lives. As seen in the above case, anxiety can also affect the lives of those with whom they live. Anxiety disorders are a group of related conditions that have increased

The College of Pharmacy Practice

This course (module 1444), in association with multiple choice questions being published in C+D August 2, provides one hour's continuing education

Reflect

Are you familiar with the symptoms of anxiety and how they are interpreted? How is anxiety treated? What are the advantages and disadvantages of drug treatment? What are the advantages and disadvantages of non-drug treatment?

Plan

This article describes anxiety, its symptoms and the different approaches to treatment: drug and non-drug therapy.

CPD This article can help in the following CPD competencies: **G1a, G1c, G1d, G1e, C1a, C1b, C1c, C1d, C3e.** See http://tinyurl.com/68ox7b

Anxiety that affects day-to-day life could be lessened by drug treatments or therapies

anxiety at their core. They differ in terms of how this anxiety presents and whether there are any trigger factors.

Generalised anxiety disorder

This is a common disorder in which individuals experience unfocused worry and anxiety unrelated to stressful life events, although these can exacerbate the level of anxiety felt. It is characterised by feelings of threat, restlessness, irritability, sleep disturbance and tension. There must be a symptom of autonomic arousal, such as palpitations, sweating, trembling or dry mouth, for a diagnosis to be made under international disease classifications.

It is relatively easy to detect anxiety symptoms; the challenge of diagnosis lies in the interpretation (see table 1, right). When does anxiety change from an understandable response to a given situation and become a more pervasive disorder that disrupts normal life? And what marks the difference between understandable worry and clinical anxiety?

In extreme presentations the distinction is straightforward. In more marginal cases rating scales, such as the Hospital Anxiety and Depression Scale, can be helpful. Overall the extent to which symptoms disrupt and impede normal daily activities can be decisive in determining severity.

Panic disorder

The symptoms are similar to those of generalised anxiety disorder. They differ in that panic disorder occurs with discrete episodes of severe anxiety, often unrelated to stressful events, although possibly exacerbated by immediate stress. Outside a panic attack, anxiety levels are typically normal, although there can be persistent worry about future panic attacks. The frequency of attacks ranges from one to several per week. Usually their occurrence is unpredictable and panic attacks, or the fear of them, can impede normal activities.

Treatment of anxiety disorders

The range of treatment options includes drug and non-drug (psychological) approaches. In practice it is essential to tailor treatment to the individual's needs.

Benzodiazepines

Benzodiazepines reduce anxiety symptoms, both in the acute setting of panic disorder and longer term presentation associated with generalised anxiety disorder. They are well tolerated and have a short onset of action. However, the potential for developing tolerance and subsequent addiction should not be underestimated. These factors limit their prescribing to two to four week periods only. Nice does not recommend benzodiazepines for panic disorder. Despite initial efficacy there is a risk of panic symptoms returning quickly when the drug is stopped, which means that long-term efficacy is reduced.

Dependence on benzodiazepines can take one of two forms. Classic substance dependence occurs with dose escalation, craving and loss of control over the drug-taking behaviour. This contrasts with the second form – therapeutic dose dependence – where there is no evidence of dose escalation or specific drug craving, though tolerance to drug effects is seen. In therapeutic dose dependency any attempt at withdrawal or substantial dose reduction produces intolerable rebound anxiety.

Choice of benzodiazepine can be based on drug potency or drug half life but is often a matter of prescriber preference. Table 2 (above) summarises the characteristics of different benzodiazepines.

Apart from the risk of dependence, benzodiazepines also pose a risk of respiratory depression, particularly if higher doses are given to an individual with already impaired respiratory function. They should be used with extreme caution in the elderly, who are more sensitive to their effects partly because of age-related hepatic impairment; doses should be one-quarter to one-half the usual adult dose.

Antidepressants

Antidepressants, especially those with a serotonergic action such as SSRIs or clomipramine, have been shown to reduce severity of anxiety symptoms, reduce frequency of panic attacks and improve overall quality of life measures. As generalised anxiety disorder is a chronic condition, long-term treatment is thought to be appropriate. But individuals with panic disorder may not see their condition as chronic and so may be reluctant to consider long-term drug therapy. As antidepressants take several weeks to be effective and can increase anxiety symptoms initially, they are not appropriate for intermittent 'when required' use. The advantage that antidepressants have over benzodiazepines is a lack of addiction potential, although there remains a risk of withdrawal symptoms with some.

Other drug options

Beta-blockers, particularly propranolol, have been used to manage anxiety symptoms. They may be effective at reducing physical, somatic symptoms, particularly tachycardia or other cardio symptoms.

Some individuals enter into an upward spiral of anxiety reinforced by physical symptoms: when they notice their heart beating faster this makes them worried, which in turn increases their heart rate further. Beta-blockers will stop this positive enforcement. However, caution is needed because of their hypotensive effects, their likelihood to cause fatigue if taken regularly and their contraindication in reversible airways disease.

Buspirone is a serotonin partial agonist

Table 1: Key symptoms of generalised anxiety

Main symptom	Prominent tension, worry and feelings of apprehension about everyday events and problems
Specific symptoms:	Three to four symptoms (below) required for diagnosis, including one symptom of autonomic arousal
– Autonomic arousal	Palpitations, sweating, trembling, dry mouth
– Chest and abdomen	Difficulty breathing, feeling of choking, chest pain, nausea, difficulty swallowing
– Mental state	Difficulty concentrating, feelings of unreality or detachment (depersonalisation), fear of losing control, fear of dying
– General	Restlessness, hot flushes (or cold chills), numbness or tingling, muscle tension, aches and pains, easily fatigued
– Sleep disturbance	Difficulty falling or staying asleep, restless unsatisfying sleep

Table 2: Benzodiazepines used in anxiety disorders

Agent	Half-life (hours)	Dosage
Alprazolam	6-12	0.25-0.5mg three times daily (max 3mg daily)
Chlordiazepoxide	5-30	10mg three times daily (max 60mg daily)
Clonazepam*	24-48	0.5mg twice daily (max 8mg daily)
Diazepam	20-100	2mg three times daily (max 30mg daily)
Lorazepam	10-18	0.5-1mg three times daily (max 4mg daily)
Oxazepam	4-15	15mg three times daily (max 60mg daily)

*Although licensed for epilepsy, clonazepam is used 'off-label" for the management of agitation and anxiety along with other psychiatric indications.

licensed for short-term management of anxiety disorders. Although well tolerated and not addictive, it is unclear how effective the drug is in practice. The Nice clinical guidelines on anxiety (CG22) state the evidence for buspirone remains equivocal. Buspirone takes a few weeks before benefit is seen so is not an appropriate choice for 'when required' medication regimens.

Other options for anxiety management include the use of sedative antihistamines or low doses of antipsychotics. Both these strategies attempt to sedate the patient without the risk of addiction posed by benzodiazepines. Evidence supporting this strategy is limited but the practice, especially using antihistamines such as promethazine or hydroxyzine, is quite widespread.

Non-drug treatment

The common psychological treatments used for anxiety disorders are cognitive behavioural therapy, dynamic psychotherapy and behaviour-based treatments such as anxiety management training.

Cognitive behavioural therapy

Cognitive behavioural therapy (CBT) links the way individuals think about themselves and the world around them and the impact this has on thoughts, feelings and behaviours. Unlike some other psychotherapies, the focus is on present difficulties rather than past events that might have caused current problems. CBT, as with other psychotherapies, can be particularly difficult if the underlying disorder impairs concentration.

Often in such severe cases drug therapy may be an appropriate first line treatment followed by non-drug therapy. CBT has been studied either alone or in combination with drug therapy for the management of anxiety disorders. It is effective given individually or as part of group therapy. When combined with medication the effects of CBT are thought to be more durable than the effects of medication alone.

Dynamic psychotherapy

Dynamic psychotherapy enables people to discuss the feelings they have for others, particularly those they are close to such as family. Discussing past experiences and how these may have contributed to present situations produces an understanding that enables individuals to make choices about the future. Not all people are able to engage with psychotherapy as it can unlock deep emotions that may have been suppressed for some time. Releasing these emotions can initially increase anxiety and be upsetting. Compared with CBT, there is much less evidence supporting dynamic psychotherapy in anxiety disorders but nevertheless regarded as appropriate.

Behaviour-based treatments

These attempt to change behaviour more directly, enabling individuals to develop new coping strategies. Fears can be overcome by helping people to spend more time in the situation they fear. New ways of managing anxiety, using breathing or visualisation, are learnt in safe environments before being applied to real situations. Individuals may be encouraged to keep diaries to see which situations trigger anxiety and how their anxiety might be improving.

Treatment strategy

Often the most appropriate strategy involves a combination of drug and non-drug treatments. If initial anxiety is severe then a short course of a benzodiazepine will be appropriate. The concurrent use of a benzodiazepine will also limit any initial increase in anxiety caused by starting an antidepressant. When the person is ready, a psychological-based assessment may be required before starting a tailored regimen of psychotherapy. The exact strategy used will depend on the individual's preferences, presenting symptoms, presence of underlying mood disorder and availability of local psychology services.

Stuart Gill-Banham MRPharmS, MCMHP, is a clinical lecturer at Medway School of Pharmacy and a member of the College of Mental Health Pharmacists.

The references are online at www.chemistanddruggist.co.uk/update

Your Continuing Professional Development CPD

Act

- Read the article by the same author on depression (C+D, Pharmacy Update, January 23, 2008, p19-22 – www.chemistanddruggist.co.uk/update).
- Read the Nice quick reference guide to anxiety http://tinyurl.com/6z59jf
- Revise the use and withdrawal of benzodiazepines in the British National Formulary.
- Read the leaflets on anxiety and phobias on the Royal College of Psychiatrists' website (www.rcpsych.ac.uk). Print any you think might be useful for patients.
- Read more about cognitive behavioural therapy and think how you would explain it to a patient (http://tinyurl.com/oy3yd)
- Update your knowledge on complementary therapies suitable for anxiety that patients might ask about (http://tinyurl.com/5geskl)
- Find out more about the Hospital Anxiety and Depression Scale, (http://tinyurl.com/5ove7n) and think about how it may help you when consulting patients.
- Find out about any counselling services in your area that might be useful to patients. Anxiety Alliance (www.anxietyalliance.org.uk/home) may run self help groups in your area or consult your local surgery.
- Think how you would persuade someone needing an antidepressant for panic attacks to take the drug long-term if they were reluctant to take chronic medication.

Evaluate

- Do you feel confident about recognising the symptoms of anxiety and panic disorder? Are you familiar with their treatment? Could you give advice to patients with anxiety?

CPD Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the August 2 issue, which will cover this month's three CPP-accredited modules. A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on **01732 377269**.

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Epoetins: new warning

The European Medicines Agency (EMEA) has asked for new warnings on the use of epoetin drugs in correcting anaemia in cancer patients.

The warnings should state blood transfusion was the preferred method, EMEA said, after a review concluded the benefits of the treatments continued to outweigh risks in the approved indications.

However, it also found the benefits did not outweigh the risk of tumour progression and short overall survival in cancer patients who might otherwise have a "reasonably" long life expectancy.
http://tinyurl.com/4hfkoc

Controversial obesity drug gets qualified Nice recommendation

Nice has given its qualified recommendation to the controversial obesity treatment rimonabant (Acomplia).

The treatment, which has been linked to problems with suicidal ideation, has not been approved in the USA, although it is available in Europe.

The treatment must be used in conjunction with diet and exercise, and only in patients who have had an inadequate response to orlistat and sibutramine, or who are intolerant of them.

Additionally, it should be continued beyond six months only if the patient has lost at least 5 per cent of their body weight since starting the treatment, and should be ended if they return to their pre-treatment weight.

Finally, the treatment should not be continued beyond two years without a formal clinical assessment, and a discussion of the risks and benefits.

Nice chief executive Andrew Dillon said that the decision was good news for patients for whom the alternative drugs were not effective, and emphasised the scale of health problems caused by obesity.

In the same announcement, Nice gave the thumbs-up to adalimumab in treating severe psoriasis not improved by other treatments, and cetuximab in head and neck cancer.
Rimonabant:
http://tinyurl.com/4fy67r
Adalimumab:
http://tinyurl.com/5kzqz5
Cetuximab:
http://tinyurl.com/69tz8m

Salmeterol cuts events

Adding salmeterol to inhaled corticosteroids in asthma reduces the risk of severe exacerbations, a metastudy published by the Annals of Internal Medicine has confirmed. However, adding the long-acting bronchodilator did not appear to cut risk of hospitalisation and may not reduce intubations or death.
http://tinyurl.com/4v4z5u

Lack of evidence halts appraisal process

Nice officials have halted appraisal processes for four cancer treatments because the makers failed to provide sufficient evidence.

The treatments were bevacizumab in treating metastatic breast cancer and non-small cell lung cancer, carmustine in addition to surgery in the management of gliblastoma multiforme, and cetuximab in colorectal cancer. The published advice in each case said that in considering whether to recommend local use of the treatments, NHS organisations should consider why the makers did not supply the information, and that they should follow DH advice for situations where Nice guidance is unavailable (see good practice link below).

A spokesperson for bevacizumab supplier Roche stated it had not provided the required evidence because it was sure the treatment would not meet Nice's cost effectiveness criteria, and added it was always difficult for an add-on treatment to meet such demands.
Nice guidance by date:
http://tinyurl.com/5yzxjh
'Good practice guidance on managing the introduction of new healthcare interventions and links to Nice technology appraisal guidance':
http://tinyurl.com/65oano

Clinical Alerts – Sign up for C+D's clinical newsletter at www.chemistanddruggist.co.uk/register

MHRA alerts and recalls

Thalidomide Pharmion has been authorised in the EU as part of a first-line combination treatment for untreated multiple myeloma in patients aged 65 years or over, and in those ineligible for high-dose chemotherapy. The treatment must be prescribed and dispensed in accordance with a pregnancy prevention programme.
http://tinyurl.com/5p45ba
Clinitest hCG Cassette (professional use only) lot numbers 97552 and 97574 manufactured by Siemens Healthcare Diagnostics. Recall due to potential for false negative results. Siemens Medical Solutions Diagnostics, 01276 696680, dx-npt_helpdesk-uk.med@siemens.com

SPC Changes

Xenical 120mg hard capsules (orlistat) Changes including list of undesirable effects. Roche Products, 0800 3281629, medinfo.uk@roche.com
APO-go PFS 5mg/ml solution for infusion in pre-filled syringe (apomorphine) Clarified information on Coombs' positivity and haemolytic anaemia. Britannia Pharmaceuticals, 01737 773741, medicalservices@britannia-pharm.com
Oily phenol injection (phenol) Change to contraindications and added special warnings. UCB Pharma, 01753 447690, medicalinformationuk@ucb-group.com
Abilify 7.5mg/ml solution for injection (aripiprazole) Extensive changes including special warnings, undesirable effects and preclinical safety data. Bristol-Myers Squibb Pharmaceuticals, 01895 523740, medical.information@bms.com
Ezetrol 10mg tablets (ezetimibe) Warning on reported dizziness, and possible effect on driving and use of machines. MSD-SP, 01992 467272.
Rhinocort Aqua 64 micrograms nasal spray (budesonide) Changes to advice on breastfeeding and undesirable effects. AstraZeneca UK, 01582 836836, medical.informationuk@astrazeneca.com
DDAVP/Desmopressin intranasal solution, Desmospray, Desmopressin nasal spray (desmopressin) Change to undesirable effects. Ferring Pharmaceuticals, 01753 214845, medical@ferring.com
Zyban 150mg prolonged release film-coated tablets (bupropion) Revised information on suicidal thinking. GlaxoSmithKline UK, 0800 221441, customercontactuk@gsk.com
Imodium capsules, syrup (loperamide) Revisions following quality review of documentation. Janssen-Cilag 0800 731 8450, medinfo@janssen-cilag.co.uk

MUR ZONE
C+D MUR Zone
Everything you need to know about setting up and carrying out MURs plus tips for all your consultations
Visit www.chemistanddruggist.co.uk/murzone

Lactose intolerance doesn't have to mean a life without the taste of dairy...

Up to 15 per cent of Britons are estimated to be lactose intolerant, but a lack of knowledge means the number could be much higher. Twenty two per cent of people surveyed said they would consult their local pharmacist for advice, making them the second most popular source of information after GPs, according to recent research.[1] Help customers to identify their condition by trying the elimination challenge diet and you'll be well positioned to offer advice on leading as normal a life as possible, without giving up the taste of dairy.

Lactose intolerance is caused by a deficiency of lactase, an enzyme present in the lining of the small intestine needed to digest lactose, which is a disaccharide present in milk and other dairy products. The condition is known as hypolactasia.

Undigested lactose moves through to the large intestine, where it is fermented by bacteria to cause abdominal symptoms, including flatulence, stomach cramps, nausea, bloating and diarrhoea.

Symptoms usually begin 30 minutes to two hours after eating and may be mistaken for irritable bowel syndrome. The condition can have a significant impact on an individual's quality of life, but may remain undiagnosed as awareness is low.

Some people are born with lactose intolerance, while others develop it later in life. Only around a third of adults retain the ability to digest lactose into adulthood. The prevalence of intolerance varies between ethnic groups, as does the age of onset. The elderly run a particularly high risk of developing symptoms when in hospital, for example, where they are often given large amounts of milk.

In people of black and Asian origin, hypolactasia usually manifests itself in early childhood, whereas in the white population it seems to occur later in childhood or in adolescence. Lactose intolerance should not be confused with allergy to milk protein, which causes allergy symptoms and is not relieved by avoiding lactose.

Among general populations, a 1994 review[2] suggests lactose intolerance is lowest in Scandinavia and north west Europe (3-8%) and close to 100% in most of south east Asia. In Europe, the frequency increases the further south and east you go.

Management

There is no cure for lactose intolerance but it can be managed by avoiding lactose in the diet, taking lactase supplements, and using milk alternatives.

Many people with lactose intolerance avoid dairy alternatives because of the taste, but Lactofree tastes just like cow's milk, it can be used in cooking and is suitable for children from the age of one. It is semi-skimmed cow's milk with more than 99.95% of the lactose removed and is the only product of its kind on the market.

Lactose intolerance can be confirmed and the extent of the intolerance determined using an elimination diet, for more details see www.lactofree.co.uk. Once intolerance levels are determined, the diet can be adjusted accordingly. Foods should not be eliminated completely and a range of calcium rich foods such as Lactofree should be included.

Tips for managing lactose intolerance:

- Check food labels as lactose is hidden in many foods
- Drink milk and eat dairy food with meals and snacks
- Try Lactofree and the Elimination Challenge Diet

With the great taste and nutritional content of milk, Lactofree is simply semi-skimmed cow's milk with the lactose filtered out. The result is a nutritious dairy drink that's at least 99.95% lactose free and is suitable for those who are lactose intolerant. It can be used in cooking and given to children from the age of one in the same way as cow's milk.

Lactofree comes in two varieties:

- **Lactofree Fresh – £1.35/litre**
- **Lactofree Longlife – £1.28/litre.**

References 1. Digestive health – a consumer & healthcare professional viewpoint, Prescient, November 2007
2. Gudmand-Hoyer E. The clinical significance of disaccharide maldigestion. Am J Clin Nutr 1994;59(3):735S–41S

Further information: www.lactofree.co.uk
Elimination Challenge Diet: www.lactofree.co.uk/assets/pdf/eliminationChallengeDiet.pdf

lactofree

For more real-life scenarios see: www.chemistanddruggist.co.uk/practicalapproach

Clinical News

EMEA approves

EMEA Committee for Medicinal Products for Human Use members have voted in favour of pramipexole (Oprymea) and lacosamide (Vimpat). They are used for, respectively, idiopathic Parkinson's disease, and as an adjunctive therapy in treating partial-onset seizures.
http://tinyurl.com/5sh262

FDA warns on Cellcept

FDA officials have warned that cases of progressive multifocal leukoencephalopathy have been reported in patients receiving Cellcept, the mycophenylate mofetil anti-rejection treatment.
http://tinyurl.com/4qeyzl

Wales unable to endorse

An appraisal of the losartan-hydrochlorothiazide combination treatment COZAAR-Comp 100/12.5 has been halted by the All Wales Medicines Strategy Group.
http://tinyurl.com/5n4x5n

Dementia patients pick herbal remedies

Half of dementia victims take herbal extracts and vitamin supplements, researchers have told the Royal College of Psychiatrists' annual meeting.

Most of the individuals do so without telling health professionals and few were aware of possible side effects of interactions, the meeting heard.

Only a minority believed they were gaining any benefit from the treatments, the researchers added.
http://tinyurl.com/rc45y

Buprenorphine comes top

A study reported in the Lancet on the effectiveness of naltrexone and buprenorphine in 126 heroin-dependent subjects has come out in favour of buprenorphine.

The authors wrote that the findings added support to the view that buprenorphine was an effective public health approach to reducing problems associated with heroin dependence.
http://www.thelancet.com

Positive rotavirus results

Sanofi Pasteur has claimed positive results for its pentavalent oral rotavirus vaccine RotaTeq. The Rotavirus Efficacy and Safety Trial shows an efficacy of 94 per cent in reducing hospital attendances due to rotavirus gastroenteritis.
http://tinyurl.com/5swhph

Mortality raised in low vitamin D

Low vitamin D levels may be associated with increased risk of all-cause and cardiovascular mortality, an Archives of Internal Medicine study has suggested.

Data from 3,258 male and female patients scheduled for coronary angiography found low levels of 25-hydroxyvitamin D and 1,25-dihydroxyvitamin D levels were independently associated with a doubled risk of death over the following 7.7 years.
http://tinyurl.com/3olo7d

MUR ZONE

Four new MUR tips are online now. Find aminosalicylates, mood stabilisers, ulcerative colitis and antispasmodics at www.chemistanddruggist.co.uk/murzone

A Practical Approach — Diabetes epidemic?

David Farram

David Spencer, pharmacist at the Update Pharmacy, has just made the monthly delivery of prescribed medicines to the Sunny Days Residential Home for the Elderly and is having a chat with Iris Bloom, the manager.

Iris says: "David, tell me, is diabetes catching?"

David laughs: "You must be joking."

"I am and I'm not," Iris replies. "Of course I know it isn't contagious, but we seem to have had something of an epidemic of diabetes here recently; four of our residents have developed it in the last few months."

David thinks for a moment. "Now you come to mention it," he says, "I've noticed more residents are being prescribed anti-diabetic medications. It does seem rather strange. I'll do some investigating when I get back to the pharmacy to see if there's an explanation."

A couple of hours later David rings Iris. "I think I may have found a linking factor for your 'epidemic'," he says. "All your new diabetic patients have been on olanzapine. Can you tell me why?"

Iris replies: "Well, you know a few of our residents have senile dementia. They are all quite harmless, but the behaviour of some of them does tend to upset the other residents. So our GP put them on olanzapine, and I must say it does calm them down."

"OK," says David, "but I'm not sure that's the right approach. I'll discuss it with the GP if that's all right with you."

Questions

1. Is there a link between olanzapine and diabetes?
2. Are there any other potential hazards to elderly patients from olanzapine?
3. Is olanzapine a suitable treatment for behavioural symptoms of senile dementia?
4. Are there more appropriate treatments?

Answers

1. Yes, there is a link between olanzapine and other atypical antipsychotics, and hyperglycaemia. An increased risk of around 1.67, compared with no antipsychotic medication use, has been reported (Lambert BL et al. Am J Epidemiology 2006 164: 672-681).
2. The Commission on Human Medicines advises that olanzapine should not be used for treating the behavioural symptoms of dementia in the elderly because it is associated with an increased risk of stroke.
3. No. Olanzapine is licensed for the treatment of schizophrenia, for manic episodes of bipolar disorder and for control of agitation and disturbed behaviour in those conditions. It is not licensed for controlling behaviour in elderly patients with dementia, and even short-term use can lead to serious events (Rochon PA et al. Arch Intern Med. 2008;168: 1090-1096).
4. Behaviour modification – rewarding appropriate or positive behaviour and ignoring inappropriate behaviour – should be attempted first. In some cases a simple cause of disturbed behaviour can be identified and addressed. Drugs to control behaviour should be used only when other approaches are ineffective and when drugs are essential for safety. Haloperidol is indicated for agitation and restlessness in the elderly. It is relatively non-sedating with low incidence of antimuscarinic side effects, but may cause extrapyramidal symptoms.

A Practical Approach

Can you suggest a scenario for Practical Approach? Email ideas to haveyoursay@cmpmedica.com

This article can help in the following CPD competencies: **G1a, G1c, C1b, C3b, C4j .** See http://tinyurl.com/68ox7b

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It will look and feel like C+D – you'll even be able to turn the virtual pages – but it will only be available online.

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09.08.08

Out for a better service

The lesbian, gay and bisexual community faces discrimination within the NHS, argues Stonewall's [illegible]

It's sometimes assumed by healthcare professionals that lesbian, gay and bisexual people don't have specific health needs as a consequence of their sexual orientation. In fact, research shows that gay people do have specific concerns around healthcare – and that these are not necessarily met. Prescription for Change, a major study into lesbian health just published by the charity Stonewall, shows alarming inequalities across the health service, revealing that hundreds of thousands of lesbian and bisexual women feel highly uncomfortable when engaging with the NHS.

Focus on men's sexual health

Since the 1980s, work on gay health issues has been predominately concerned with the sexual behaviour of gay men, and preventing and treating HIV and Aids. While there's no doubt this focus on 'safe sex' has been absolutely vital, it means wider health issues for gay men have largely been overlooked, while the health needs of lesbian and bisexual women remains one of the most neglected research areas in healthcare.

Gay men do of course have health needs other than those related to sexual activity and HIV prevention. Research shows gay men are concerned about a range of issues including mental health, weight issues and eating disorders, a lack of role models, and relationships. Some are also concerned about smoking, and drug and alcohol abuse.

Lesbians and STIs

By contrast, if some medical professionals fail to see beyond sexual health issues for gay men, there remains a common misconception that lesbians are not at any risk of sexually transmitted infections (STIs). Yet women do contract STIs from each other and need to be tested for asymptomatic diseases such as chlamydia. Some pharmacists have been known to mishandle cases, such as offering female partners shared treatment for STIs. Fewer than half of lesbian and bisexual women have ever been screened for STIs.

Smoking and alcohol

Stonewall's new report found that two-thirds of lesbian and bisexual women have smoked compared to half of women in general. Nine out of 10 lesbian and bisexual women drink, and 40 per cent drink three times a week compared to a quarter of women in general. It's likely that social pressures to drink and smoke are more prevalent among the gay community.

Popular culture demonstrates that lesbian and gay people often congregate in bars and clubs, and therefore many feel this is the natural place to go and meet other gay people in a safe space. This is changing – in larger cities, it's increasingly possible for gay people to meet others through a range of social networks, often based around activities such as sports and popular interests. Yet there is still an emphasis on smoking and alcohol consumption and a culture that encourages excessive drinking.

> "Fewer than half of lesbian and bisexual women have ever been screened for STIs"

Lesbian and gay people tell us that one of the difficulties with giving up smoking, or seeking support for problem drinking, is that preventive healthcare messages are often not targeted at them. Only recently a national stop smoking campaign stated that 'smoking makes you unattractive to the opposite sex'. Clearly, this completely fails to communicate with lesbian and gay people, meaning they're less likely to be receptive to anti-smoking messages which don't speak to them. Interestingly, high profile anti-smoking campaigns aimed at gay communities have run in the USA for years.

There have been some steps to remedy this. Islington PCT, for example, offers a smoking cessation group targeted at lesbians to encourage them to seek support in an environment free from the risk of discriminatory reactions from other service users. For lesbians, incentives to give up smoking will often differ to those for heterosexual women. Pregnancy is often a trigger for women to quit, but won't be an incentive to all lesbian and gay women.

Those who offer support services to stop smoking should ensure as a matter of course that they don't make assumptions about a customer's sexual orientation.

Prescription for change

Prescription for Change reveals that 15 per cent of lesbian and bisexual women over the age of 25 have never had a cervical smear test, compared to 7 per cent of women in general. Some healthcare professionals continue to believe lesbians do not require cervical smear tests, based on the assumption that cervical cancer is caused by exposure of the cervix to sperm. One in 50 lesbians has been refused a cervical smear. Research suggests there are other causes of cervical cancer, including sexual behaviour (including having unprotected sex at a young age – some lesbians may have done this), smoking and diet. This indicates that all women with a cervix should receive cervical screening.

A 'wake-up call'

The Equality Act (Sexual Orientation) Regulations 2007, in force since last April, makes it unlawful for service providers, including health services, to refuse lesbian and gay people treatments they would offer to anyone else. The law might have changed, but with widespread examples of gay people still encountering discrimination within the health service, what's needed now is greater awareness and understanding of the specific needs of gay and lesbian people.

Many healthcare providers have taken marked steps forward to improve services for lesbian and gay people, yet it's clear that this progress has not been replicated across the country. There's still some way to go before everyone in Britain is afforded access to the health services they need and deserve.

For more report findings and Stonewall's recommendations for the NHS, go to

Category M Barometer

While the instability caused by last year's dramatic category M clawback continues to spark debate, the tariff has since maintained a stable footing. The latest revision shows no significant change in the reimbursement value of category M for the third quarter running.

Since the inception of category M, generics use has continued to grow significantly as a result of growth in prescriptions and medicines coming off patent. The significant fluctuations in reimbursement, such as witnessed in Q4 2007, are due to the Department of Health keeping track of these changes and attempting to keep the agreed purchase profit levels in line. With the proposed changes to the PPRS, all reimbursement will now be linked and the system thoroughly modernised.

It is clear, therefore, that we are in a more settled period. And, in a year with very few off patents to rely upon, pharmacists must decide where the value in their business exists and focus accordingly. Not only is it important to continue to work within the tariff to ensure opportunities such as dispensing the appropriate pack size are maximised, but it is also critical pharmacists take advantage of payment for services.

In addition, the mix of supply from manufacturer and wholesaler would appear to be more important than ever. While it may sometimes pay to shop around for the best deal, at stable and historically low reimbursement levels for volume lines, it would suggest that the movement to manufacturer schemes will continue unabated.

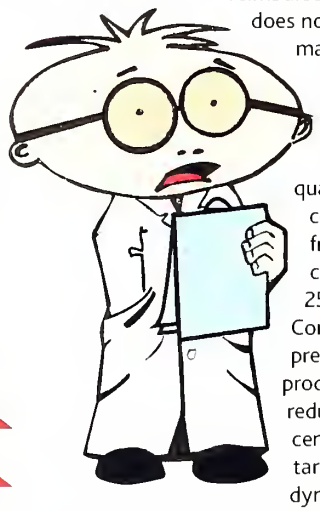
-£4.7m

July-September 2008

The annualised amount of money removed via category M

Post-tariff analysis with Generic Eric:

The Category M Barometer Index edged down to 49.2 from the previous quarter's figure of 49.3 – remember this is a statistical analysis that tracks how reimbursement has varied since category M was introduced in April 2005 and indicates the direction in which reimbursement has moved. It does not account for market growth.



As we can see from the tables, the largest decrease this quarter sees 34 per cent being removed from the price of cefalexin tablets 250mg x 100. Compared with previous tariffs, where products have been reduced by over 50 per cent, this indicates the tariff hasn't been overly dynamic.

This point is also reflected in this quarter's risers, although four show an increase of over 50 per cent and the 80 per cent rise in chloramphenicol demands attention.

Examining the range of products that were in category M when it was launched also provides some insight. Previously, the reimbursement level of the core products listed in category M in April 2005 had been rising as other products – generally off patents – entered the tariff.

For the first time this year, the core range will be reimbursed at a higher level than the previous quarter. We can therefore surmise the majority of the savings from this quarter have been taken from products that have entered category M following its inception.

This represents a new trend of stability and, assuming that purchase profit is maintained as per the pharmacy contract, this should lock in the agreed profits for retail pharmacy depending on the mix of products for the individual outlet. It also indicates the department has reverted back to its usual method of calculating the tariff.

What's hot

Product	pack size	April 2008 tariff	July 2008 tariff	changes	% changes
Chloramphenicol 0.5% eye drops	10ml	£1.39	£2.50	+£1.11	80%
Salbutamol 5ml oral solution 2mg	150ml	£1.06	£1.64	+£0.58	51%
Trihexyphenidyl 2mg tablets	84	£9.15	£13.84	+£4.69	51%
Paracetamol 500mg tablets	32	£0.46	£0.69	+£0.23	50%
Ibuprofen 600mg tablets	84	£3.18	£4.53	+£1.35	42%

What's not

Product	pack size	April 2008 tariff	July 2008 tariff	changes	% changes
Cefalexin 250mg tablets	100	£10.11	£6.72	-£3.39	-34%
Pergolide 1mg tablets	100	£32.25	£21.46	-£10.79	-33%
Haloperidol 10mg tablets	28	£9.06	£6.20	-£2.86	-32%
Haloperidol 1.5mg tablets	28	£2.84	£1.95	-£0.89	-31%
Beclometasone 100mcg inhaler	200 dose	£15.16	£10.60	-£4.56	-30%

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HOW TO BUY GENERICS

Products in brief

Treat their feet

Novartis is targeting men with a downloadable footcare guide offering information on hygiene and making feet more presentable. A survey carried out for Novartis's Lamisil Once athlete's foot treatment found 75 per cent of men spend nothing on foot grooming products and some 40 per cent suffered from athlete's foot. Download the guide at [illegible] Novartis; tel: 01403 210211

For Aquafresher breath

Aquafresh Extreme Clean Pure Breath toothpaste is the latest addition to the Aquafresh range. The new paste gives the triple protection of Aquafresh Extreme Clean and includes zinc to reduce breath odour by over 85 per cent immediately after brushing. It also has a whitening effect on teeth.

Packaging highlights the fresh breath benefits and the addition of zinc.

Price: £2.49/100ml
GlaxoSmithKline
Tel: 0845 762 6637

LOVE YOUR MOUTH
www.loveyourmouth.co.uk

GSK's oral campaign

'Love Your Mouth' is the message GlaxoSmithKline is putting across to consumers in a new £3.65 million oralcare campaign.

The oralcare awareness campaign is supporting GSK's five main oralcare brands – Aquafresh, Corsodyl, Macleans, Poligrip and Sensodyne. A website [illegible] has been set up that features a 'Mouth Match' test to enable consumers to work out which products will deliver the oral health benefits they need.

Throughout July and August the campaign and the five brands will be supported through TV, radio and internet advertising as well as in-store promotion and PR.

Product info:
GlaxoSmithKline
Tel: 0845 762 6637
www.loveyourmouth.co.uk

Oral-B targets caries

Oral-B's oral health symposium in Glasgow focused on the issue of dental caries. Leading experts spoke to delegates about the latest thinking on the diagnosis and management of dental caries.

Dr Marc Hense, professional marketing manager at Oral B, commented: "We are delighted with the efforts of the NHS to push forward prevention of dental caries in England by providing an evidence-based toolkit for prevention."

Oral-B has just introduced the Oral-B Triumph with SmartGuide to the Oral-B ProfessionalCare range of rechargeable toothbrushes, which uses rotating-oscillating technology.

The new brush features a wireless display unit with a visual display of the mouth to encourage good brushing habits.

Price: £139.99
Procter & Gamble
Tel: 01932 896000

TV return

Lil-lets is on TV this month for the first time in five years. The £1.5 million campaign will put across the 'Designed for comfort' message, targeting women aged 30 to 45. The ads will be backed by press, PR and a relaunched website – [illegible]

Product info:
Lil-lets UK
Tel: 0121 270 8100

King of Shaves boasts Brit razor

Shaving products brand King of Shaves has launched a razor to go with the range. Claimed to be the first British designed, engineered and manufactured razor in over 100 years, the King of Shaves Azor has been developed by founder of the company Will King.

The Azor claims to shave closer, last longer and cost less than its competitors. Key features include a patented elastomer skin bumper and pivot system, which pushes the blades progressively closer into the skin, a wishbone shaped head for better visibility while shaving and an ergonomically designed handle.

The Azor comes in two colours, with more planned for next year. It's initially available at Sainsbury's and Boots, and open to other retailers in the autumn. The launch is being backed by a multi-million pound marketing spend.

Price: £4.99
Pip codes: black handle 339-7809; white handle 339-7817; 4-pack blades 339-7825; 8-pack blades 339-7833
King of Shaves
Tel: 020 8834 1817

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Verrucas and warts get the big freeze

New to the Carnation range for summer is Carnation Footcare Cryospray Verruca & Wart Remover Freeze spray.

The freeze spray treats verrucas and warts quickly and effectively with just one application. The verrucas and warts then take 10 to 14 days to disappear. The treatment can be used on children from age four. It is not suitable for diabetics or for use in pregnancy.

Price: £9.99/50ml can with 12 disposable applicators
Pip code: 325-6872
Cuxson Gerrard
Tel: 0121 544 7117

Flash a whiter smile

Sunstar GUM has launched a range of four tooth whitening products for a brighter smile.

The Original White toothbrush is battery-operated and produces vibrations to activate micro-bubbles of foam to enhance the effect of Original White toothpaste.

Original White floss is coated with micronised silica and fluoride to remove stains. Original White toothpaste helps whiten teeth without harsh abrasives and bleaching agents.

To finish, Original White mouthwash contains antioxidants and allantoin to remove stains and keep gums healthy.

Prices: Original White floss £2.75; toothpaste £3.50; mouthrinse £6.95; sonic toothbrush £11.99; twin pack heads £5.60
Trinity Sales & Marketing
Tel: 01235 838590

Poligrip for summer

Poligrip Ultra is being advertised on TV with a new campaign running until the end of July with a spend of £865,000.

In a testimonial style advert, 65-year-old Geoff tells how Poligrip Ultra helps him to lead an active life. The ad ends with the message 'Speak, eat and smile with confidence.'

Product info:
GlaxoSmithKline
Tel: 0845 762 6637

Soft Rosy for lips

Vaseline Rosy Lips has been added to the Vaseline lip therapy range. The new variant contains rose and sweet almond oil to moisturise lips while giving them a soft pink tint.

The new Lip Therapy addition is expected to further grow the market, which last year saw 10.8 million people purchase lip balm.

Price: £1.49
Unilever
Tel: 020 8439 6100

Oil's well in a capsule

Aquamarine is a new fish oil product from Vitabiotics that combines omega 3 and cod liver oil in one capsule. They are orange flavoured so there is no fishy after-taste.

Price: £6.95/60 capsules
Pip code: 324-7277
Vitabiotics
Tel: 020 8955 2600

Products advertised on TV next week

Benadryl Allergy Relief: All areas
Bepanthen: All areas
Canesten: All areas
Curanail: GMTV, C4, Sat
Feminax Ultra: All areas
First Response Early Results Pregnancy Test: All areas
Frontline Spot On: GMTV, five, Sat, West Country
Lamisil Once: All areas
Lanacane Anti Chafing Gel: All areas
OdorEaters: All areas
PerspireX: Sat
Poligrip: All areas
Scholl Cracked Heel Repair Cream: All areas except CTV, LWT, CAR
Sensodyne: All areas
PharmaSite for next week: Solpadeine – windows, **Solpadeine** – in-store, **Solpadeine** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

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The white paper wants all pharmacy students to have 'meaningful' clinical experience. **Colin Rodden** considers the practicalities

Training gets real

There is an interesting section on undergraduate education in the Pharmacy in England White Paper. The intention is to integrate clinical experience throughout the undergraduate curriculum. Although not being fully cognisant of current undergraduate courses, I see this as a laudable aim, as my impression is that there is often little interaction between the students' daily life and the real world they will encounter on leaving academia. A series of placements of one day a week for several weeks is no substitute for a longer, continuous period spent in a clinical environment.

Achieving 'meaningful' clinical experience might be a challenge. How is meaningful defined? Surely it should be that students should only have clinical placements in specialities they have covered in their curriculum.

How 'meaningful' will it be for a group of students to attend a cardiology unit before they have studied the physiology, pharmacology and therapeutics of the heart and circulatory system? The underpinning theoretical knowledge must be present before they can get the most out of the placement. It would not be 'meaningful' to substitute an introductory lecture with a placement. Of course, the training would also include professional aspects too, presumably both in hospital and community settings, with experience in skills such as dispensing, counselling and teamwork.

A lot of thought will need to go into changes to the undergraduate curriculum to ensure that placements can be timetabled appropriately. Depending upon the number of schools of pharmacy and hospitals in an area, this may also involve co-ordination between schools. If a specialist unit covers a large area, there may be several schools sending students to it. High student numbers might overwhelm the unit and make them less likely to accommodate visits in future. Likewise the capacity of community pharmacies in the area to cope may be tested.

Medical undergraduate teaching in hospitals has been part of the course for a very long time. Pharmacy is only taking the first tentative steps in this area. In the current economic and target-driven climate, it might prove more difficult to achieve. Which leads on to another consideration. Who is going to be teaching the students? My colleagues, who currently have students on placements with them for a day a week, do not have the capacity to extend this any further. Teaching is not a major part of their employment. Employers are unlikely to tell the universities to send as many students as they wish, as they will have to employ extra pharmacists to facilitate the training.

Rather, they are more likely to request significant funding from the schools to resource this major change in education. It will not be the more junior members of staff who would be expected to carry out the training. It would have to be the experienced, specialist pharmacist, otherwise the placement could not be as 'meaningful' as it should be. For the same reason, it is unlikely to be university staff sent out with the students. The experience should be of practical application of the theoretical learning with an expert, experienced practitioner. There is already concern in the system about hospital pharmacies being swamped by the change in pre-registration pharmacist training to a six-month hospital/six-month community split. To add undergraduate training could be a recipe for meltdown.

Would this be mitigated by the white paper suggestion of merging undergraduate and pre-registration years? This could potentially solve a number of timing problems as there would now be five years within which the course contents could be shuffled. It would not, however, solve the resource issues. It would also require a radical rethink by the Royal Pharmaceutical Society, or the General Pharmaceutical Council and new professional body, on how the content of the pharmacist pre-registration year is incorporated into the undergraduate course. Will there still be a pre-registration pharmacist (sorry, pre-registration trainee pharmacist as they are now to be called) examination at the end of the year? Or will that be incorporated into the degree course? Will future students graduate and go straight on to the register?

One last thought. This white paper is for pharmacy in England. Surely changes to the undergraduate course will affect all the schools? Those in Scotland, Wales and Northern Ireland would be forced down this route, whether they want to or not. To do otherwise would risk the creation of a two-tier education system.

Colin Rodden is national secretary for Scotland, Guild of Healthcare Pharmacists

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The CHEMIST AND DRUGGIST

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NHS gets green light as contractors strike a deal

TWO YEARS OF DEPUTATIONS AT THE MINISTRY OF HEALTH

Representatives of the Joint Negotiating Committee and the Company Chemists Association began talks on the NHS terms in 1946

"It is beyond dispute that July 5, 1948, will remain one of the most significant dates in the history of pharmacy," said C+D, two days before the National Health Service Act came into operation.

Although some pharmacists were said to welcome the reforms, others, who had a considerable volume of private dispensing, were reported to be facing serious losses.

A feature on the conversion of the existing National Health Insurance Service into the NHS concluded: "On the whole, a readjustment of the mechanism and management of the pharmacist's world may be expected as a result of NHS operations, bringing him more into line with the majority of other professional and scientific workers and developing for him the better elements of his craft in a move towards attaining the highest professional standards."

The NHS terms for contractors in England and Wales in 1948 included:

¥An average dispensing fee of one shilling per prescription

¥ Expensive prescriptions to be individually priced

¥A container allowance of 2s 5d (pence) for every prescription

¥ Higher dispensing fees for prescriptions involving special techniques.

The rules:

¥ Pharmacists required to provide the service between 9am and 6pm.

¥ Pharmacists expected to help themselves and the country by an extensive recovery of bottles for re-use

¥Three months notice required to withdraw from the NHS.

Golfing flashback

Golf was not far from the pharmacy agenda even in 1948. At the Ulster Chemists' Golfing Society's June meeting that year, C+D reported that the McMullan Cup was awarded to a Mr JC Watt after he defeated Mr W Powell in the final.

Toilet takeover

Despite the birth of the NHS on July 5, 1948, C+D's top news story of the week was nonetheless the Toilet Preparations (Revocation) Order, which lifted controls on the manufacture and supply of toilet preparations.

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The way of the world in 1948

January

¥Nationalisation of UK railways to form British Railways

¥Burma gains independence from the UK

¥Indian pacifist and leader Mahatma Gandhi is murdered

February

¥Ceylon (later renamed Sri Lanka) becomes independent within the British Commonwealth

¥The Communist Party seizes control of Czechoslovakia

March

¥Hells Angels founded in California

April

¥The World Health Organization is established by the United Nations

May

¥Declaration of Independence of Israel

June

¥The Deutsche Mark becomes official currency of the future Federal Republic of Germany

¥The Empire Windrush brings the first group of several hundred immigrants to Tilbury near London from Caribbean countries, heralding the start of multicultural Britain

July

¥1948 Summer Olympics begin in London, the first Summer Olympics since World War II

August

¥Establishment of the Republic of Korea

September

¥Invasion of the State of Hyderabad by the Indian Army on the day after the Pakistani leader Jinnah's death to assist damage control

October

¥The 1948 Ashgabat earthquake kills 100,000

November

¥United States presidential election – Harry S Truman defeats Thomas E Dewey and Strom Thurmond for the presidency

¥Operation Magic Carpet to transport Jews from Yemen to Israel begins

December

¥United Nations General Assembly adopts Universal Declaration of Human Rights

¥Last Soviet troops withdraw from North Korea

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